TC 94-61
Rev. 8-03

KENTUCKY TRANSPORTATION CABINET
DIVISION OF DRIVER LICENSING

MEDICAL REVIEW BOARD AFFIDAVIT

FOR USE IN REPORTING A DRIVER FOR POSSIBLE PHYSICAL/MENTAL IMPAIRMENT, RECEIPT OF THIS REPORT WILL RESULT IN A REVIEW BY THE MEDICAL REVIEW BOARD. THIS FORM MAY BE USED BY A PHYSICIAN, COUNTY OFFICIAL OR THE KENTUCKY STATE POLICE. WHEN USED BY CITIZENS OF THE COMMONWEALTH, TWO SIGNATURES ARE REQUIRED.

FULL NAME:_____
First Middle Last

SOCIAL SECURITY NUMBER:_____ DATE OF BIRTH:_____
Month/Day/Year

CURRENT ADDRESS:_____
Street City State Zip Code

List reasons why you feel the above named individual can not safely operate a motor vehicle. List any driving behaviors you have witnessed, all medical ailments you are aware of, or incident leading to this affidavit. (WE ARE REQUIRED TO RELEASE THIS DOCUMENT UPON REQUEST BY THE SUBJECT.)

_____

_____

_____

_____

_____
If additional space is required, please use reverse side.

Signature #1:_____ Date:_____

_____
Name Street City State Zip Code

Signature #2:_____ Date:_____

_____
Name Street City State Zip Code

Subscribed and sworn to before me this_____ day of_____, 20_____.

Signature:_____

Title:_____

My Commission Expires:_____

Please return completed form to:
Medical Review Board
Division of Driver Licensing
State Office Building
Frankfort, KY 40622